

**STATE OF GEORGIA
COUNTY OF FULTON
CITY OF SOUTH FULTON**

RESOLUTION NO. 2017-038

**A RESOLUTION AUTHORIZING THE CITY TO APPLY TO OBTAIN
WORKERS' COMPENSATION INSURANCE COVERAGE THROUGH THE
GEORGIA MUNICIPAL ASSOCIATION**

WHEREAS, the City of South Fulton ("City") is a municipal corporation duly organized and existing under the laws of the State of Georgia;

WHEREAS, pursuant to Act 421 of the 2016 session of the Georgia General Assembly (the "City Charter"), the City of South Fulton incorporated on May 1, 2017;

WHEREAS, the City employs and intends to continue to employ persons to assist with City functions;

WHEREAS, pursuant to O.C.G.A. § 34-9-1, *et seq.*, the City must provide Workers' Compensation coverage to its employees in the event of work place injuries;

WHEREAS, pursuant to O.C.G.A. § 34-9-154, the City may comply with its duties as an employer to provide workers' compensation through membership in a Group Self-Insurance Fund;

WHEREAS, the Georgia Municipal Association ("GMA") Workers' Compensation Self-Insurance Fund satisfies and exists for such purpose;

WHEREAS, the City Council finds that membership in the GMA Workers' Compensation Self-Insurance Fund is beneficial to and in the best interests of the City;

BE IT HEREBY RESOLVED by the Mayor and City Council, as follows:

1. The aforesaid recitals are not mere recitals, but are material portions of this Resolution.
2. The City Council authorizes the Mayor to execute, on behalf of the City of South Fulton, the GMA's Application for Membership in Group Self-Insurance Fund ("Application"), a copy of which is attached hereto, and any other documents necessary to enroll the City as a member in the GMA Workers' Compensation Self-Insurance Fund.
3. Upon approval of the Application, the City shall subscribe to and abide by the GMA Workers' Compensation Self-Insurance Fund's intrastate agreement,

bylaws, rules, and regulations as well as the rules and regulations of the Insurance Commissioner of the State of Georgia related to the GMA Workers' Compensation Self-Insurance Fund.

4. Coverage provided by the GMA Workers' Compensation Self-Insurance Fund shall initially cover all City Administration, Clerical, and Parks and Recreation staff and said coverage shall be amended as necessary to cover all other employees of the City as they transition or become hired to perform work as employees of the City.

The foregoing Resolution No. **2017-038**, adopted on **August 8, 2017** was offered by Councilmember **Baker**, who moved its approval. The motion was seconded by Councilmember **Jackson**, and being put to a vote, the result was as follows:

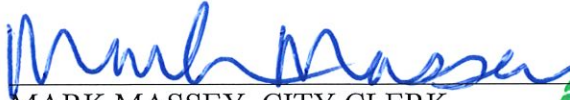
	AYE	NAY
William "Bill" Edwards, Mayor	<hr/>	<hr/>
Catherine Foster Rowell, Mayor Pro Tem	<hr/> √	<hr/>
Carmalitha Lizandra Gumbs	<hr/> √	<hr/>
Helen Zenobia Willis	<hr/> √	<hr/>
Gertrude Naeema Gilyard	<hr/> √	<hr/>
Rosie Jackson	<hr/> √	<hr/>
khalid kamau	<hr/> √	<hr/>
Mark Baker	<hr/> √	<hr/>

THIS RESOLUTION adopted this 8th day of August 2017. CITY OF SOUTH FULTON, GEORGIA



WILLIAM "BILL" EDWARDS, MAYOR

ATTEST:



MARK MASSEY, CITY CLERK

APPROVED AS TO FORM:



JOSH BELINFANTE, INTERIM CITY ATTORNEY





Ralph T. Hudgens
Insurance Commissioner

**GEORGIA INSURANCE DEPARTMENT
STATE CAPITOL
ATLANTA, GEORGIA**

GMA WORKERS COMPENSATION
INSURANCE FUND

Sponsored by the Georgia
Municipal Association

**APPLICATION FOR MEMBERSHIP
IN GROUP SELF-INSURANCE FUND**

To the Insurance Commissioner of Georgia and the GEORGIA MUNICIPAL ASSOCIATION
SELF INSURANCE WORKERS COMPENSATION FUND.

As of 12:01 a.m., _____, application is hereby made for membership in
the GEORGIA MUNICIPAL ASSOCIATION SELF INSURANCE WORKERS
COMPENSATION FUND.

- (1) Member Name _____
- (2) Address _____
- (3) Telephone Number _____
- (4) Federal Employer I.D. Number _____
- (5) Nature of Business _____ City Government _____
- (6) Type of Business _____ Commission _____
- (7) Chief Administrative Officer _____

- (8) Locations of all operations to be included in the Fund:

<u>NAME</u>	<u>PRINCIPAL ADDRESS</u>	<u>TYPE OF BUSINESS</u>
City of _____	_____	Municipality _____

- (9) If the applicant is *unable* to obtain all the information requested in item 9, it may instead include a certification signed by the Administrator or Chairman of the Board of Trustees of the Fund that the information actually provided is satisfactory to the Fund.

Loss History for last three completed years:

	20____ <u>YEAR ENDING</u>	20____ <u>YEAR ENDING</u>	20____ <u>YEAR ENDING</u>
a. Number of accidents requiring medical attention only	_____	_____	_____
b. Number of accidents requiring loss time of more than three days	_____	_____	_____
c. Total paid claims	\$ _____	\$ _____	\$ _____
d. Outstanding reserves	\$ _____	\$ _____	\$ _____
e. Total incurred losses (Paid and Reserves)	\$ _____	\$ _____	\$ _____
f. Fatalities in the last three years	No _____	Yes _____	Number _____

If yes, explain: _____

(10) Estimated premium for 12 month period beginning Month _____ Day _____ Year _____

Classification Code	Classification Description	Estimated Annual Payroll	Current Rate	Estimated Annual Premium
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(SEE ATTACHED)

TOTAL PAYROLL _____ TOTAL PREMIUM _____

(11) Present carrier of workers' compensation insurance or indicate if applicant participated in a workers' Compensation self-insurance program. _____

(12) Present workers' compensation premium. _____

(13) Safety, sanitation and welfare conditions:

Is your business or any part thereof inspected otherwise than by State authority? _____

If so, by whom? _____

Have you fulfilled all safety requirements of the State Board of Workers' Compensation? _____

Have you a committee of safety whose duty is to recommend safety devices and to secure compliance with statues or general orders of the Board of Workers' Compensation as to safety and sanitation? _____

Do you maintain a hospital in connection with your works? _____ If so, state description of its equipment and service. _____

(14) In consideration for the approval of this application, the applicant agrees as follows:

- That the applicant will comply with Code Title 114, the Regulations promulgated there under, all lawful Orders of the Commissioner, the Rules and Orders of the State Board of Workers' Compensation, and the rules, regulations and bylaws of this Fund.
- That the applicant will be jointly and severally liable for all obligations of the Fund during the entire period of membership in the Fund.
- That the applicant will pay promptly any lawful premiums or assessments due as a member of the Fund.
- That the applicant will submit and "Application to Withdraw from Group Self-Insurance Fund" ninety (90) days prior to voluntary withdrawal from the Fund.
- That coverage under this membership shall be for Georgia operations only, including incidental coverage in other states.
- That the applicant will notify the Fund and the Commissioner within fourteen (14) days of any change in any of the information contained in questions 1 through 8 of this application.

William "Bill" Edwards, Mayor
(Print Name of Applicant)

By: William Edwards
(Signature of Authorized Official)

William Bill Edwards
(Print Name)

Mayor
(Print Title)

Date: 8/11/2017